

**Virginia Health Practitioners' Monitoring Program  
Monthly Group Attendance Report – Substance Use Disorder**

Name of Participant: \_\_\_\_\_ Client # \_\_\_\_\_ CM: \_\_\_\_\_  
 Date of Report: \_\_\_\_\_ For Month: \_\_\_\_\_, 20\_\_\_\_ Sobriety Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Twelve-Step Meetings (Group Type A):**

(Examples: AA, NA, CA, SA, Al-Anon, CODA, etc.)

Number of meetings required: <<# in contract>> Number of meetings attended: \_\_\_\_\_

Do you have a sponsor? ☐ Yes ☐ No

Number of contacts: Telephone \_\_\_\_\_ Face-to-Face \_\_\_\_\_ Meetings \_\_\_\_\_ Other \_\_\_\_\_ ☐ No Contact

**Healthcare Professionals Meetings (Group Type B):**

(Examples: Caduceus, IDAA, Nurse's Support Group, Facilitated Aftercare, etc.)

**Required Treatment/Aftercare Groups Do Not Count Toward Required Healthcare Professionals Meetings**

Number of meetings required: <<# in contract>> Number of meetings attended: \_\_\_\_\_

**Complete date, group type, the meeting topic, and if you shared.**

(Please use additional pages if necessary)

Week	Date	*Group Type	Topic	Did You Share?
1	_____	A <input type="checkbox"/> B <input type="checkbox"/>	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
1	_____	A <input type="checkbox"/> B <input type="checkbox"/>	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
1	_____	A <input type="checkbox"/> B <input type="checkbox"/>	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
1	_____	A <input type="checkbox"/> B <input type="checkbox"/>	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
2	_____	A <input type="checkbox"/> B <input type="checkbox"/>	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
2	_____	A <input type="checkbox"/> B <input type="checkbox"/>	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
2	_____	A <input type="checkbox"/> B <input type="checkbox"/>	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
2	_____	A <input type="checkbox"/> B <input type="checkbox"/>	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
3	_____	A <input type="checkbox"/> B <input type="checkbox"/>	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
3	_____	A <input type="checkbox"/> B <input type="checkbox"/>	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
3	_____	A <input type="checkbox"/> B <input type="checkbox"/>	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
3	_____	A <input type="checkbox"/> B <input type="checkbox"/>	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
4	_____	A <input type="checkbox"/> B <input type="checkbox"/>	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
4	_____	A <input type="checkbox"/> B <input type="checkbox"/>	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
4	_____	A <input type="checkbox"/> B <input type="checkbox"/>	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
4	_____	A <input type="checkbox"/> B <input type="checkbox"/>	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>

**What have you gained from meeting attendance this month?**

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(Please fax this form to 804-828-5386 by the 10<sup>th</sup> of the month. Thank you for your cooperation!)

**For Office Use Only:**

Date Received by HPMP: \_\_\_\_\_ Case Manager: \_\_\_\_\_  
 12-Step \_\_\_\_\_ Caduceus \_\_\_\_\_ IDAA \_\_\_\_\_ Facilitated Aftercare \_\_\_\_\_ Nurse's Support Group \_\_\_\_\_ Other \_\_\_\_\_